

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
INDIVIDUAL SUPPORT PLAN (ISP)
CHANGES IN THE ISP

INDIVIDUAL'S NAME (<i>Last, First, M.I.</i>)	DATE
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Use this form to describe and document changes in the annual ISP.

TYPE OF CHANGE(S)

Check all that apply. For (*), attach the DDD-1351A, Notice of Action to Suspend, Reduce or Terminate Service for ALTCS funded services.

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| <input type="checkbox"/> NEW OBJECTIVE/OUTCOME | <input type="checkbox"/> TERMINATE A SERVICE* |
| <input type="checkbox"/> DISCONTINUE OBJECTIVE/OUTCOME | <input type="checkbox"/> ADD NEW SERVICE |
| <input type="checkbox"/> REVISED OBJECTIVE/OUTCOME | <input type="checkbox"/> CHANGE TEAM AGREEMENT/ASSIGNMENT |
| <input type="checkbox"/> REDUCE FREQUENCY OF CURRENT SERVICE* | <input type="checkbox"/> OTHER (<i>Specify</i>): _____ |

DESCRIPTION OF CHANGE(S)

Use the space below to describe the specific change(s) being made, e.g., list new objective or the service and units to be provided.

REASON FOR CHANGE(S)

PRINT NAME OF PERSON SUBMITTING CHANGE	SIGNATURE OF PERSON SUBMITTING CHANGE	DATE
PRINT NAME OF SUPPORT COORDINATOR	SUPPORT COORDINATOR'S SIGNATURE	PHONE NO.
		DATE

The support coordinator has explained the change(s) to me. I understand that service is provisional and may require further approval, subject to ALTCS requirements and/or state funding. I also understand that if I disagree with the change(s) and wish to request mediation or an Administrative Review, I must request one within 35 days of the date of this change notice.

<input type="checkbox"/> Agree <input type="checkbox"/> Request team meeting before change Return a signed copy to your support coordinator in-person or mail to: _____ _____ _____ _____	<p style="text-align: center;">For State Funded Services</p> <input type="checkbox"/> Disagree <input type="checkbox"/> Disagree and request mediation <input type="checkbox"/> Disagree and I will request an Administration Review <p>To request a mediation or Administration Review as checked above, this form is being submitted to my Support Coordinator, or I will mail, call, fax or deliver in person to:</p> <p style="text-align: center;">Division of Developmental Disabilities Compliance and Review Unit P.O. Box 6123 - Site Code 791A 1789 West Jefferson St., 4th Flr. Phoenix, Arizona 85005</p> <p style="text-align: center;">OR Telephone (602) 542-6859 OR FAX (602) 364-2850</p>	
PRINT NAME OF RESPONSIBLE PERSON	SIGNATURE OF RESPONSIBLE PERSON	DATE

It is your responsibility to obtain any needed assistance and to submit your request within the time specified. If you have any questions, please contact your Support Coordinator.

Routing: **White** - Support Coordinator File, **Canary** - Responsible Person, **Pink** - Provider

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